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Sociodemographic Profile, Reasons for Institutionalization and Physical Comorbidities among Elderly Residents of a Rural Old Age Home in South India.

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Abstract

Background: Weakening of the traditional joint family, widowhood, destitution and chronic illness are driving increasing numbers of Indian elderly into old age homes. Understanding who these residents are, why they are institutionalized and what physical illnesses they carry is essential for planning services, particularly in under-studied rural institutions. ***Aim:*** To describe the sociodemographic profile, reasons for and duration of stay, and physical comorbidities of elderly residents of a rural old age home, and to examine their association with psychiatric screening status. ***Materials and Methods:*** Sixty consenting residents aged 60 years and above of an old age home at Hosakote, Bengaluru Rural were assessed in a cross-sectional design using a semi-structured proforma, the Modified Kuppuswamy scale (2021), clinical examination, and the MINI-Plus screener. Chi-square test was used with $p < 0.05$ considered significant. ***Results:*** Residents were predominantly aged 60–70 years (50%), female (60%), of rural origin (56.7%), unemployed (60%) and of lower socioeconomic strata; 30% were illiterate. Only 25% were currently married, while 73.3% were separated, widowed, divorced or otherwise single. Destitution (33.3%) was the leading reason for admission, followed by widowhood (16.7%) and psychiatric illness (16.7%); 55% had stayed more than 10 years. Hypertension (46.7%) and diabetes (21.7%) were the commonest physical illnesses. Overall, 75% screened positive on MINI-Plus, but no sociodemographic factor was significantly associated with screening status. ***Conclusion:*** The typical resident of this rural old age home was an elderly woman without a marital partner, of low education and socioeconomic status, admitted for destitution and carrying chronic physical illness. These psychosocial adversities coexisted with a very high burden of psychiatric morbidity, warranting integrated medical, psychiatric and social care.

Keywords: Elderly; Old age home; Institutionalization; Sociodemographic factors; Widowhood; Comorbidity.

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INTRODUCTION

The world is ageing rapidly, and older persons form the fastest growing segment of the population in most countries, including India (1). Population ageing brings with it distinctive medical, psychological and social needs, and geriatric health has accordingly become a major public health concern in India (2). The Indian family has traditionally been the primary source of care and material support for the elderly, and looking after ageing parents has been regarded as the moral and social duty of children. However, urbanization, industrialization, migration of the young for employment and the shift from joint to nuclear families have progressively eroded this support system (2).

As a result of these transformations, institutions such as old age homes have come to play an increasingly important role in the care of older adults who have no one to look after them. Elderly persons enter such homes for a variety of reasons, including destitution, widowhood, chronic medical or psychiatric illness, disability, conflict with children and daughters-in-law, financial constraints and, at times, personal preference (3,4). Life in an institution, however, is itself a significant psychosocial transition: residents must cope with rigid routines, separation from family and familiar surroundings, loss of social roles, restricted autonomy and repeated exposure to the illness and death of fellow inmates (3).

The profile of old age home residents reported from different parts of India shows certain recurring features: a preponderance of women, largely explained by their longer life expectancy and the earlier loss of the spouse; low levels of literacy and income; and a high frequency of widowhood and separation (4-7). Physical multimorbidity is common, with

hypertension, diabetes mellitus, musculoskeletal disorders and sensory impairment being frequently documented (5,8). These physical illnesses, along with loneliness, financial dependence and lack of family support, are recognized risk factors for depression and other mental disorders in institutionalized elderly, in whom psychiatric morbidity is consistently higher than in the community (3,6,7,16).

Knowledge of who lives in old age homes, why they came, how long they stay and what illnesses they suffer from is a prerequisite for planning appropriate services, including medical outreach, psychosocial support and welfare measures. Most available Indian data are drawn from urban institutions (3,4,6), while rural old age homes, whose residents may differ in education, occupation, socioeconomic status and access to health care, remain comparatively under-studied. The present study was therefore undertaken to describe the sociodemographic characteristics, reasons for and duration of institutionalization, and physical comorbidities of elderly residents of a rural old age home in South India, and to examine whether these factors were associated with psychiatric screening status, so that the psychosocial determinants of institutionalization and ill health in this vulnerable group may be better understood.

MATERIALS AND METHODS

This observational, cross-sectional study was carried out over a period of 18 months in Shanthi Mandir, a non-governmental old age home for destitute persons established in 1981 at Hosakote, Bengaluru Rural, which is linked to the community psychiatry services of the Department of Psychiatry of a medical college and research hospital. Approval of the Institutional Ethics Committee and permission of the authorities of the old age home were obtained before commencing the study.

All residents aged 60 years and above of either sex who gave informed consent were eligible. Residents below 60 years, those who declined consent, and those with severe debilitating medical or surgical comorbidities were excluded. The sample size, calculated with p = 50%, q = 50% and an absolute precision of 13% at the 95% confidence level, was 57 and was rounded to 60; sixty residents fulfilling the criteria were recruited by convenience sampling. The study was explained to each resident in the vernacular language and written informed consent was taken; for residents unable to give consent, it was obtained from the attenders after verifying details with the in-charge of the home.

A semi-structured proforma designed for the study was used to record name, age, gender, religion, area of residence, education, occupation, marital status, duration of stay in the old age home and the reason for admission. Socioeconomic status was graded using the Modified Kuppuswamy socioeconomic scale (2021 revision), which classifies families into upper, upper middle, lower middle, upper lower and lower classes on a total score ranging from 3 to 29 (13). A detailed medical history was taken and a thorough clinical examination was performed to document physical comorbidities such as hypertension, diabetes mellitus, hypothyroidism and neurological disorders.

Psychiatric screening status was ascertained using the Mini International Neuropsychiatric Interview-Plus (MINI-Plus), a short structured diagnostic interview for DSM-IV and ICD-10 disorders that takes approximately 15 minutes to administer (10); cognition was assessed with the Mini Mental State Examination (11), and diagnoses in screener-positive residents were confirmed against ICD-10 criteria (12), the details of which are reported separately.

Data were entered in Microsoft Excel and analysed using SPSS version 22 (IBM SPSS Statistics, Somers, NY, USA). Categorical variables were summarized as frequencies and percentages. The Chi-square test was used to examine the association between sociodemographic and institutional variables and MINI-Plus screening status, with $p < 0.05$ taken as statistically significant.

RESULTS

Table 1: Basic sociodemographic characteristics of the residents (n = 60)

Variable	Category	n	%
Age (years)	60–70	30	50.0
	70–80	21	35.0
	80–90	6	10.0
	>90	3	5.0
Gender	Male	24	40.0
	Female	36	60.0
Religion	Hindu	45	75.0
	Christian	9	15.0
	Muslim	6	10.0
Native residence	Urban	26	43.3
	Rural	34	56.7

Half of the residents were in the 60–70 year age band and only 15% were older than 80 years. Women (60%) outnumbered men, three-fourths were Hindus, and a majority (56.7%) originally hailed from rural areas (Table 1).

Table 2: Education, occupation and socioeconomic status (n = 60)

Variable	Category	n	%
Education	Illiterate	18	30.0
	Primary or below	21	35.0
	High school	12	20.0
	Bachelor degree	5	8.3
	Master degree	4	6.7
Occupation	Unemployed	36	60.0
	Employed	24	40.0
Socioeconomic status	Class I (upper)	6	10.0
	Class II (upper middle)	10	16.7
	Class III (lower middle)	15	25.0
	Class IV (upper lower)	16	26.7
	Class V (lower)	13	21.7

Educational attainment was low: 65% of residents were either illiterate or educated only up to primary school, and only 15% had a university degree.

Three-fifths were unemployed, and nearly half (48.4%) belonged to the upper-lower and lower socioeconomic classes of the Modified Kuppuswamy classification, although 10% belonged to the upper class (Table 2).

Table 3: Marital status of the residents (n = 60)

Marital status	Count	%
Single (never married)	1	1.7
Married	15	25.0
Separated	17	28.3
Widowed	14	23.3
Divorced	10	16.7
Widower	3	5.0
Total	60	100.0

Only a quarter of the residents were currently married. Separation (28.3%), widowhood (23.3% widowed women and 5% widowers) and divorce (16.7%) together accounted for nearly three-fourths of the sample, indicating that the overwhelming majority of residents lacked a marital partner (Table 3).

Table 4: Duration of stay and reason for admission to the old age home (n = 60)

Variable	Category	n	%
Duration of stay	<1 year	3	5.0
	1–10 years	24	40.0
	10–20 years	22	36.7
	>20 years	11	18.3
Reason for stay	Destitute	20	33.3
	Widowed	10	16.7
	Psychiatric illness	10	16.7
	Medical illness	9	15.0
	Disability	5	8.3
	Others	6	10.0

Stay in the institution was typically prolonged: 55% of the residents had lived in the home for more than 10 years and 18.3% for more than 20 years.

Destitution was the single largest reason for admission (33.3%), followed by widowhood and psychiatric illness (16.7% each), medical illness (15%) and disability (8.3%); other reasons (10%) included having nobody to care for them at home, children living away, problems with children and personal preference (Table 4).

Table 5: Physical comorbidities among the residents (n = 60)

Medical illness	Count	%
Hypertension	28	46.7
Diabetes mellitus	13	21.7
Neurological illness	2	3.3
Hypothyroidism	1	1.7
Diabetes + hypertension + hypothyroidism	1	1.7
Hypertension + hypothyroidism	1	1.7
Hypertension + neurological illness	1	1.7
Others (heart disease, amputation, cataract, hearing impairment)	9	15.0

Hypertension was the commonest physical illness, present in 46.7% of the residents, followed by diabetes mellitus in 21.7%.

Three residents had combinations of two or three chronic illnesses, and 15% had other conditions including heart disease, leg amputation, cataract and hearing impairment (Table 5).

Table 6: Association of sociodemographic and institutional factors with MINI-Plus screening status (n = 60)

Variable	Category	Positive n (%)	Negative n (%)	p value
Age (years)	60–70	24 (53.3)	6 (40.0)	0.315
	70–80	13 (28.9)	8 (53.3)	
	80–90	5 (11.1)	1 (6.7)	
	>90	3 (6.7)	0 (0.0)	
Gender	Male	17 (37.8)	7 (46.7)	0.543
	Female	28 (62.2)	8 (53.3)	
Education	Illiterate	15 (33.3)	3 (20.0)	0.825
	Primary or below	14 (31.1)	7 (46.7)	
	High school and above	16 (35.6)	5 (33.3)	
Occupation	Unemployed	30 (66.7)	6 (40.0)	0.068
	Employed	15 (33.3)	9 (60.0)	
Marital status	Married	14 (31.1)	1 (6.7)	0.138
	Without partner	31 (68.9)	14 (93.3)	
Socioeconomic status	Class I–III	23 (51.1)	8 (53.3)	0.852
	Class IV–V	22 (48.9)	7 (46.7)	
Duration of stay	≤10 years	21 (46.7)	6 (40.0)	0.765
	>10 years	24 (53.3)	9 (60.0)	
Reason for stay	Destitute	15 (33.3)	5 (33.3)	0.208
	Other reasons	30 (66.7)	10 (66.7)	

Forty-five residents (75%) screened positive on the MINI-Plus. None of the sociodemographic or institutional variables — age, gender, religion, education, residence, occupation, marital status, socioeconomic status, duration of stay or reason for stay — was significantly associated with screening status (all $p > 0.05$). A non-significant trend was noted for occupation, unemployed residents forming 66.7% of the screener-positive group against 40% of the screener-negative group ($p = 0.068$) (Table 6).

DISCUSSION

The age structure of our sample, with half the residents aged 60–70 years and progressively fewer in older bands, matches the pattern described in several Indian old age home surveys (4,5,7) and reflects declining survivorship with age as well as the tendency to seek institutional care soon after retirement. The female preponderance (60%) is likewise a near-universal finding in Indian institutions (4-7): women live longer than their typically older husbands, and once widowed are often excluded from family rituals, left without income — most having been homemakers — and eventually admitted to old age homes.

Consistent with this, only 25% of our residents were currently married, while separation, widowhood and divorce together accounted for nearly three-fourths of the sample, echoing reports in which more than a third of institutionalized elderly were widowed (4,6,7). Low education (65% illiterate or primary-schooled) and unemployment (60%) were prominent, as in other Indian studies of old age home inmates (4,5,7), and are readily explained by the rural catchment of this home, where schooling was historically sacrificed for agricultural work and where limited working capacity, physical illness and

financial dependence render older adults unemployable. Almost half the residents belonged to the upper-lower and lower socioeconomic classes; notably, however, 10% belonged to the upper class and had sought institutional care simply because they were alone or their children lived abroad, illustrating that loneliness rather than poverty alone drives institutionalization.

Destitution was the leading reason for admission (33.3%), followed by widowhood, psychiatric illness, medical illness and disability, in broad agreement with studies identifying homelessness, family decisions, loss of spouse, chronic somatic disease and mistreatment by sons and daughters-in-law as the principal antecedents of institutionalization (3,4,14,15). More than half the residents had stayed beyond 10 years, suggesting that admission is effectively permanent once family ties are severed. Hypertension (46.7%) and diabetes (21.7%) were the leading physical comorbidities, mirroring the high rates of hypertension (above 37%) reported across institutional and community geriatric samples in India (5,8,9), and underscoring the double burden of chronic physical disease and psychosocial adversity carried by these residents.

Although 75% of the residents screened positive for psychiatric disorder, no sociodemographic factor achieved statistical significance, with only a trend for unemployment; the small single-institution sample and the uniformly disadvantaged background of the residents probably limited the power to detect associations, and comparative studies with community controls have similarly required larger samples to demonstrate such effects (6,7,16). The convenience sampling and cross-sectional design are further limitations. Nonetheless, the profile that emerges — an elderly, poorly educated woman without a partner, admitted for destitution and living for a decade or more with untreated chronic disease — identifies a clearly vulnerable population for whom integrated geriatric services, welfare support, regular medical care and psychosocial intervention within old age homes are urgently required (2,3).

CONCLUSION

Residents of this rural old age home were predominantly women in the seventh decade of life, of rural origin, poorly educated, unemployed and drawn largely from the lower socioeconomic strata. Three-fourths lacked a marital partner, destitution and widowhood were the principal reasons for admission, stays were typically longer than a decade, and chronic physical illnesses — chiefly hypertension and diabetes — were widespread.

These psychosocial and physical adversities coexisted with a very high rate of positive psychiatric screening, though no single factor was independently associated with it. Old age homes, particularly in rural areas, should therefore be equipped with regular medical services, mental health liaison and structured psychosocial activities, and social policies must address widowhood, destitution and family neglect that push the elderly into institutions.

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